BIRTH GEOGRAPHIES: RACE, REPRODUCTIVE JUSTICE, AND THE POLITICS OF THE HOSPITAL

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INTRODUCTION

In July 2020, as the United States was engulfed in pandemic and protest, Woodhull Medical Center in the Bedford-Stuyvesant neighborhood of Brooklyn attracted national attention.[1] On July 2nd, a few days after her due date, Sha-Asia Washington went to Woodhull for a routine stress test.[2] Her doctors discovered her blood pressure was high and gave her Pitocin to induce her labor and an epidural.[3] Washington's boyfriend told reporters that

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[1] E.J. Dickson, *Death of Sha-Asia Washington, Pregnant 26-Year-Old Black Woman, Highlights Devastating Trend*, ROLLING STONE (Jul. 9, 2020), https://www.rollingstone.com/culture/culture-features/shaasia-washington-death-woodhull-hospital-black-maternal-mortality-rate-1026069/ [https://perma.cc/WQ6M-TX6F]; Emily Bobrow, *She Was Pregnant With Twins During Covid. Why Did Only One Survive?*, N.Y. TIMES (Aug. 6, 2020), https://www.nytimes.com/2020/08/06/nyregion/childbirth-Covid-Black-mothers.html [https://perma.cc/DQA2-GMW7]; Alyssa Newcomb, *Pregnant 26-year-old's Death Sheds Light on Health Care System that Fails Black Mothers*, TODAY (Jul. 15, 2020), https://www.today.com/health/death-sha-asia-washington-sheds-light-racial-disparities-black-mothers-t186898 [https://perma.cc/5D9L-L34W]; Ally Mauch, *Death of Pregnant Black Woman, Sha-Asia Washington, Highlights Racial Disparities in Maternal Mortality*, PEOPLE (Jul. 10, 2020), https://people.com/health/death-of-pregnant-black-woman-sha-asia-washington-highlights-racial-disparities-in-maternal-mortality/ [https://perma.cc/L9UP-CMBQ].

[2] *See* Dickson, *supra* note 1.

[3] Journalistic coverage has debated whether Washington consented to the epidural. Dickson reports, "The hospital ended up giving her Pitocin, a medication that causes uterine contractions, to induce labor, asking Sha-Asia if she wanted an epidural. After some hesitation, she assented." *See* Dickson, *supra* note 1. Rose Adams writes:

> On July 2, [Washington] and her boyfriend visited Woodhull Medical Center, a city-run hospital on Flushing Avenue. [Washington] went into labor the following day, and shortly before midnight on July 3, doctors escorted [Washington]'s boyfriend out of the room and gave [Washington] an epidural despite her protests, her boyfriend's family said. "They were giving her too much medication. She said she didn't want [the epidural], and they forced it on her," said Jasmin López, a close friend of [Washington]'s and the sister of her boyfriend.

he next saw his girlfriend raced to the operating room where doctors performed an emergency C-section.[4] He never saw her alive again. The family's independent autopsy determined that the epidural was the cause of Washington's death.[5] A week later, Woodhull released a statement[6] about Washington's death, situating it in the context of Black maternal mortality in the US, in New York, and in Bedford-Stuyvesant, which the City's Department of Health concluded has one of the highest rates of maternal complications in the city.[7] For activists, Washington's death was intimately related to two other cases of Black maternal death that had received considerable local attention in New York in 2020—Amber Rose Isaac[8] and Cordielle Street.[9] EJ Dickson reported, "Washington's story has since gone viral as a symbol of the dire need for improved medical care for black mothers,"[10] and by mid-July, New York State Senator Julia Salazar had released a statement noting "Sha-Asia's story is devastating, and it is far too familiar. . . . Ms. Washington's death is for each of us a call to action."[11]

Maternity wards also appeared in the national news as media turned its attention to Englewood, a neighborhood in Chicago's South Side.[12] Kelly

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Rose Adams, *Protesters Slam Bed-Stuy Hospital After Black Woman Dies During Childbirth*, Brooklyn Paper (Jul. 9, 2020), https://www.brooklynpaper.com/they-killed-her-protesters-slam-bed-stuy-hospital-after-black-woman-dies-during-childbirth/ [https://perma.cc/4PDG-Z69G].

[4] *See* Dickson, *supra* note 1.

[5] *See* Adams, *supra* note 4.

[6] Their statement noted, "Our heartfelt condolences are with the family, friends and community who bear the pain of this unspeakable loss. The persistently high rates of maternal mortality that disproportionately affects people of color is a grave, national crisis. Here in New York City, we will not stand for this status quo, and remain undeterred in our mission to eliminate structural inequities and guarantee comprehensive and quality care for all New Yorkers." Heather Marcoux, *This Pregnant Mother's Death Highlights Racial Disparities in Maternal Care,* Motherly (Jul. 13, 2020), https://www.mother.ly/news/sha-asia-washington-death-maternal-care [https://perma.cc/92D7-MBXS].

[7] N.Y.C. Dep't of Health and Mental Hygiene Bureau of Maternal, Infant, and Reproductive Health, Severe Maternal Morbidity, 2008-2012 (2016) at 16.

[8] Two weeks before her death, Isaac tweeted "Can't wait to write a tell all about my experience during my last two trimesters dealing with incompetent doctors at Montefiore [Hospital]." *See* Irin Carmon, *When Your Zip Code Determines Whether You Live or Die*, N.Y. Mag. (May 5, 2020), https://nymag.com/intelligencer/2020/05/when-your-zip-code-determines-whether-you-live-or-die.html [https://perma.cc/Y7N6-4NTT].

[9] *See* Claudia Irizarry Aponte, *Brooklyn Woman's Death During Childbirth Spurs Renewed Outcry Over Treatment Disparities,* The City (Jul. 9, 2020), https://www.thecity.nyc/health/2020/7/9/21319623/brooklyn-womans-childbirth-death-maternal-racial-disparities [https://perma.cc/7KW2-R39S].

[10] Dickson, *supra* note 1.

[11] Press Release, Julia Salazar, N.Y State Senator, Statement on Sha-Asia Washington's Passing and Maternal Morbidity (July 15, 2020), https://www.nysenate.gov/newsroom/press-releases/julia-salazar/july-15-update-statement-sha-asia-washingtons-passing-and [https://perma.cc/CFX4-232E].

[12] *See* Kelly Glass, *When Maternity Wards in Black Neighborhoods Disappear*, N.Y. Times (May 5, 2020), https://www.nytimes.com/2020/05/05/parenting/coronavirus-black-maternal-mortality.html [https://perma.cc/5QGP-QW5M]. This article is part of increasing journalistic attention to the shuttering of maternity wards, though this coverage often focuses on the crisis facing rural pregnant people. *See, e.g.*, Naomi Abraham, *Hospital Maternity Wards Are Closing Across U.S.*, Women's E-News (Jan. 20, 2011), https://

Glass covered the "disappearance" of the maternity ward in Black neighborhoods for *The New York Times*, describing how shuttered maternity wards in Chicago's South Side created a highly racialized topography: the "maternity-care desert."[13] These deserts only intensified during COVID-19 when St. Bernard Hospital, located in Englewood, also stopped delivering babies ostensibly to protect laboring parents and newborns from the potential of exposure to COVID-19.[14] During the pandemic, the South Side was left with only three hospitals with functioning maternity wards—Mercy, University of Chicago, and Roseland—and Roseland was under investigation after a pregnant woman died.[15] Unlike the discourse around Sha-Asia Washington's death at Woodhull Medical Center, which figured the hospital's presence as producing Black maternal death, Glass's article suggests the hospital's absence is responsible for Black maternal death.[16] One resident said about St. Bernard's closure, "It's heartbreaking. . . . It's in the heart of the hood. Most black people in the neighborhood were going to go there."[17]

In these two widely circulating accounts of Black perinatal health and anti-Black obstetric violence, we see competing accounts of the place of the hospital in the enduring but newly visible crisis of Black maternal health. In one account, the hospital is a brutally present actor, a death-world for Black women, the setting for coercive and invasive medical intervention, and a space synonymous with violence. In another account, the hospital is a ghostly presence that has abandoned Black mothers, obligating them to

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womensenews.org/2011/01/hospital-maternity-wards-are-closing-across-us/ [https://perma.cc/84Y4-E3V7]; Catherine Pearson & Frank Taylor, *Rural Maternity Wards Are Closing, And Women's Lives Are On The Line*, HUFFINGTON POST. (Sept. 25, 2017), https://www.huffpost.com/entry/maternity-wards-closing-mission_n_59c3dd45e4b06f93538d09f9 [https://perma.cc/6JW6-UGAK].

[13] *See* Glass, *supra* note 12. Various sources—ranging from scholars to NGOs—deploy the term "maternity-care desert." *See* March of Dimes, NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE U.S., (2018), https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf [https://perma.cc/X5M6-NAQK].

[14] At the time of writing this article, St. Bernard is still not delivering babies. Their website indicates:

> We were forced to take this action in order to respond more effectively to the increase in patients who are sick with the COVID-19 coronavirus. Our Women's Wellness Clinic, located in our Ambulatory Care Center, will continue to treat expectant mothers and provide prenatal care. We will facilitate a connection to Mercy Hospital and Medical Center for women who need labor and delivery care. We believe these actions will provide the safest environment for expectant mothers, infants, families and our staff. ST. BERNARD HOSP. , SERVICE CHANGES: EFFECTIVE MONDAY, APRIL 20, ST. BERNARD HOSPITAL WILL NOT DELIVER BABIES UNTIL FURTHER NOTICE, https://www.stbh.org/services/labor-and-delivery-obstetrics-unit/ [https://perma.cc/NT69-24RL].

[15] *See* Glass, *supra* note 12; Lisa Schencker, *South Side Hospital Failed to Properly Triage a Pregnant Woman Who Later Died, Illinois Regulators Find*, CHI. TRIB. (July 3, 2020), https://www.chicagotribune.com/coronavirus/ct-coronavirus-roseland-hospital-investigation-20200702-5kpgjr2qtnfnffjpxrwdn5peci-story.html [https://perma.cc/Z9SE-S5RV] (describing the investigation into Roseland Community Hospital).

[16] *See* Glass, *supra* note 12.

[17] *Id.*

travel long distances to secure prenatal care and delivery, a trend that marks not only urban centers marked by entrenched residential segregation like Chicago,[18] but also rural counties across the country that are increasingly marked by the lack of OBGYNs and by a lack of maternity wards.[19] At once overly present and wholly absent, the hospital has come to signify the problems of the present crisis of Black maternal health.

But how might we understand a moment when reproductive justice advocates *both* decry the absence of neighborhood hospitals that have produced maternal care deserts *and* the over-presence of the hospital in the lives of Black perinatal people? This article argues that reproductive justice advocates[20] have largely focused on the hospital as the preeminent site of obstetric violence and medical racism and as largely responsible for the deadly outcomes we see for Black women and their children. This is not wrong. But I argue that this lens—a singular focus on the hospital as the site of Black mothers' injuries—is far too narrow to capture the conditions of the present. Instead, I contend that reproductive justice advocates would benefit from the perspective I advance in this article, which I term "birth geographies."

Birth geographies is a perspective attentive to how race, gender, and space collide and collaborate to shape birth outcomes, birth inequities, and access to perinatal citizenship.[21] I use the term "perinatal citizenship" to capture how the time surrounding birth triggers an extraordinary state interest in birthing bodies. This is an interest in their conformity to medicalized ideas of wellness, their willingness to adopt risk mitigation logic *well before* pregnancy—during the "zero trimester"—and *well beyond* pregnancy.[22] This interest can take myriad forms from regulation to surveillance, from encouragement to support. Perinatal citizenship describes how "correct" body management, comportment, and decision-making during the perinatal period can render a birthing subject a citizen, recognizable, legible, and visible as worthy of protection. And, conversely, "incorrect" body management, comportment, and decision-making can remove a birthing body from this

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[18] *See* Whet Moser, *Chicago Isn't Just Segregated, It Basically Invented Modern Segregation*, CHI. MAG. (Mar. 2017), https://www.chicagomag.com/city-life/March-2017/Why-Is-Chicago-So-Segregated/ [https://perma.cc/X5L4-ZGVW].

[19] Only 6.4% of obstetricians and gynecologists in the United States practice in rural settings. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *Health Disparities in Rural Women Committee Opinion Number 586*, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/health-disparities-in-rural-women [https://perma.cc/65TM-XTEB].

[20] I treat "reproductive justice advocates" as Black feminist activists committed to maternal justice, birthing freedom, and reproductive autonomy beyond the frames of choice that have long excluded women of color generally, and Black women specifically.

[21] Though I introduce the term "perinatal citizenship" here, I develop this argument further in my earlier work. *See generally,* JENNIFER C. NASH, BIRTHING BLACK MOTHERS (2021).

[22] For more on the "zero trimester," see MIRANDA R. WAGGONER, THE ZERO TRIMESTER 4 (2017) (defining the "zero trimester" as "a concerted focus on the months or years prior to conception in which women are urged to prepare their bodies for a healthy pregnancy").

protected status, rendering the body suspect, troubling, dangerous, and even criminal. A birth geographies perspective enables us to see how law and medicine collaborate to shape Black birth topographies, ranging from access to lactation consultants to access to legal accompanied home birth. This is a perspective attuned to thinking about the racialized and gendered politics of credentialization, certification, and professionalization, politics which impact Black mothers' lives—and Black providers' lives—in material and often undertheorized ways that shape urban and rural spaces. And it is a perspective that reckons with how Black maternal mortality and morbidity are entrenched social manifestations of gendered anti-Blackness that far exceed the space of the hospital, which can be resolved neither by the insertion of doula "bodyguards" in institutionalized medical spaces nor by homebirths, even as both have been advocated by some reproductive justice advocates.[23] The geographical perspective allows us to see the hospital as merely one actor in a web of legal and medical actors, as merely one of the factors—rather than *the* factor—shaping Black maternal health outcomes. This perspective also reveals that the labor facing reproductive justice activists is even bigger than we might think, because the scope and scale of the inequities facing Black mothers and their infants far exceeds the space of the hospital.

This article's argument unfolds in three parts: first, I trace the complicated and at times contradictory reproductive justice stance toward the hospital, tracing how the hospital is both represented as overly present and

[23] For some of this advocacy, see Allison McGevna, *Are Doulas the Key to Help Save Black Mothers' Lives?*, MOTHERLY (Jun. 6, 2019), https://www.mother.ly/news/could-doulas-help-save-black-mothers-lives [https://perma.cc/24Y8-75UV] (arguing "[i]mproved outcomes for moms who have access to doulas are well-documented. According to NPR, in some communities where doulas are utilized in higher numbers, the C-section rates are lower and women are more likely to attend prenatal care visits. This is huge for marginalized groups, like African American and Native American women, who are dying at four times the rate of white women during labor or in the months after[ ]") (citing Kenneth J. Grubert et al., *Impact of Doulas on Healthy Birth Outcomes*, 22 J. PERINATAL EDUC. 49, 54-57 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/ [https://perma.cc/ST5H-PVG6]); Catherine Pearson & Lena Jackson, *Why We Need More Black Doulas*, HUFFINGTON POST. (Feb. 28, 2019), https://www.huffpost.com/entry/why-we-need-more-black-doulas_l_5c6aff56e4b0b9cc78ff2b3f [https://perma.cc/6J6S-ZG8Z] ("I think we need more providers of color across the board, so women have the option of working with a person of color if that's important to them. Because it can be comforting to see someone who understands your lived experience. Of course, just seeing a provider who is a person of color does not mean they're going to provide great care—but I do think it's all about options."); Lisa Rab, *The Secret to Saving the Lives of Black Mothers and Babies*, POLITICO (Dec. 15, 2019), https://www.politico.com/news/magazine/2019/12/15/black-mothers-matter-079532 [https://perma.cc/N6GM-APWA] (noting "[s]tudies show that doulas help reduce the rate of caesarean surgeries, which is higher among black women than other racial groups, and other costly interventions. Doulas also increase the rate of breastfeeding, which improves the health of new moms and babies and is less common among black or low-income women. They can even alleviate some of the socioeconomic factors that contribute to poor maternal health, such as limited access to education or social support networks") (citing Katy B. Kozhimannil et al., *Potential Benefits of Increased Access to Doula Support During Childbirth*, 20 AM. J. MANAGED CARE 340 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5538578/ [https://perma.cc/74GE-U3YU]).

wholly absent. I treat this contradiction as emblematic of Black feminism's unresolved relationship to questions of institutionality and as a conflict that reproductive justice advocates must resolve as we continue to imagine a different kind of future. Do we want a reformed hospital? Do we believe hospitals can be reformed? In what ways do we want them to be more attentive, and in what ways do we feel Black mothers have simply received the wrong kind of attention, one that results in violence? Does our commitment to abolition extend to the hospital, which has long been identified as itself a site steeped in carceral logics? Indeed, while I focus on how this contradiction unfolds in the context of Black maternal health, we might consider how it unfolds in other now highly public and highly charged debates, perhaps most visibly around the movement to defund the police.

Second, I argue that a focus on the hospital (either its presence or its absence) misses how the hospital is situated at the intersections of medicine and law and how this intersection fundamentally shapes Black maternal health outcomes. A focus on medical racism makes the hospital seem as if its anti-Black actions are exclusively at the hands of providers, rather than grappling with how law and medicine collaborate not just to produce what Khiara M. Bridges calls our "two-tiered medical system" but also to produce systems of credentialization and certification that profoundly stratify medical care.[24] In thinking about the intersections of law and medicine, I treat systems of credentialization, standardization, and professionalization as shoring up raced and classed hierarchies and leaving Black women and children bearing the cost. Finally, I conclude by advancing a perspective that I argue would benefit birth justice advocates—one cognizant of birth geographies. I argue that this perspective allows us to think about multiple forms of access simultaneously, ranging from access to breastfeeding support to the regulation (and criminalization) of certified professional midwives (CPMs), to the rise of the research hospital maternity unit and the disappearance of the local hospital. This conception helps us think about geographies of birth access, care, and support, of which the hospital is only a part. This article, then, is an effort to intervene in and reshape conversations about reproductive justice rooted in my fundamental belief that these conversations have the capacity to alter the birth landscape for Black birthing people as Black birthers struggle for autonomy, equity, and what Joshua Chambers-Letson calls simply and profoundly "More Life."[25]

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[24] *See* Press Release, Boston Univ. School of Law, Law Professor Khiara Bridges Publishes New Book (Aug. 16, 2011), http://www.bu.edu/law/events/newsletters/healthlaw/2011fall/bridges.shtml [https://perma.cc/GL87-XU8Z].

[25] Joshua Chambers-Letson, After the Party: A Manifesto for Queer of Color Life xxi (2018). Chambers-Letson's work focuses on the meaning and potential of performance for minoritarian life, noting that performance can become a space where "still life (still being alive) becomes the grounds on which one improvises More Life into reality. The tradition of the oppressed, though marked by defeat and great sadness, is also the tradition of transforming still life into More Life. . . . Despite the ravages of colonialism, white supremacy, heteropatriarchy and capitalism, the persistence and extraordinary

I. *Theorizing the Crisis: Reproductive Justice and the Politics of the Hospital*

The last five years have been marked by a new journalistic and popular attention to Black maternal health.[26] Black maternal mortality—a long-standing problem fundamental to American life—has come into public view through the political efforts of Black Lives Matter, the tireless labor of reproductive justice advocates, and through the activist labor of journalists newly committed to covering this decidedly old crisis. Reproductive justice, as a movement and a political worldview, is a Black feminist critique of prevailing feminist conversations about reproduction that read abortion, access to contraception, and maternal health through the language of choice. As a political project, reproductive justice has developed an intersectional approach to thinking about reproductive access, reproductive labor, and care work together, foregrounding questions of access, safety, and survivability. The coverage of the Black maternal health crisis has largely made visible the anti-Black violence of obstetric care and its deadly effects on Black mothers and children. This awareness has brought change, if not yet reflected in Black maternal health outcomes or in the lived realities of Black mothers' lives,[27] then at least indicated discursively by the American Association of

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beauty of minoritarian life is a testament to this fact. And while we *must* demand more than just "still life," hope and performance can be powerful tools in the struggle to realize such demands." Noah Fields, *More Life: An Interview with Writer and Performance Theorist Joshua chambers-Letson*, Scapi Mag. (Dec. 4, 2018) (emphasis in original), https://scapimag.com/2018/12/04/more-life-an-interview-with-writer-and-performance-theorist-joshua-chambers-letson/ [https://perma.cc/JN69-L4UV].

[26] I describe the outpouring of journalistic attention and the crisis-framing in my book. *See* Nash, *supra* note 21. Danielle Jackson describes an "outpouring of news stories, from multiple national outlets, about infant and maternal mortality over the past twelve months." Danielle Jackson, *A Frustrating Year of Reporting on Black Maternal Health*, LongReads (June 13, 2018), https://longreads.com/2018/06/13/a-frustrating-year-of-reporting-on-Black-maternal-health/ [https://perma.cc/LQ9L-KWMC]. For a sampling of this coverage, see Shelia M. Poole, *Digging Deeper: Fighting the Lopsided Likelihood of Black Women Dying in Childbirth*, Atlanta J. Const. (Apr. 25, 2019), https://www.ajc.com/news/local/fighting-the-lopsided-likelihood-black-women-dying-child-birth/yjmHqNDxVkJbnIScOUr86J/ [https://perma.cc/UF9V-LXV6]; Sarah Hosseini, *Black Women Are Facing a Childbirth Mortality Crisis*, Wash. Post (Feb. 28, 2019), https://www.washingtonpost.com/lifestyle/2019/02/27/Black-women-are-facing-child-birth-mortality-crisis-these-doulas-are-trying-help/ [https://perma.cc/3VDS-3WNN]; Alison Bowen, *Black Moms in Illinois 6 Times More Likely to Die from Pregnancy Related Conditions*, Chi. Trib. (Oct. 19, 2018), https://www.chicagotribune.com/lifestyles/ct-life-Black-women-mortality-childbirth-20181018-story.html [https://perma.cc/U2XJ-NJVH]; Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. Times Mag. (Apr 11, 2018), https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html [https://perma.cc/CY7Q-CGV5].

[27] Danielle Jackson describes this curious intersection of attention and inertia, noting, "The inaction and confusion at the state and federal levels say a lot about gridlock and bureaucratic disorganization, but also, who and what we value in our society." Jackson, *supra* note 26. Her work underscores how the discursive explosion marked by temporalities of urgency often stands in for political work designed to ameliorate the very conditions that produce the "crisis." Haile Eshe Cole echoes the sense that the amplification of

Pediatrics' statement on race and racism,[28] myriad state reports collecting and reporting data on Black maternal mortality and morbidity, and state and national legislative efforts to mitigate the crisis.[29]

If Black maternal morbidity and mortality are the visible manifestations of a social problem—namely, anti-Black discrimination—what is the imagined locus of this harm, the place where it is felt? Much of the scholarship and activist work on the material experiences of obstetric violence has focused on the hospital: the scene of violence (the delivery room), the violent actor (the healthcare provider), and the technology of violence (the epidural, the C-section, the refusal to listen, the denial of pain management medications). In her description of obstetric violence, Elizabeth Kukura writes:

> obstetric violence may include forced cesareans or episiotomies, the physical restraint of a laboring woman, unconsented medical procedures or verbal abuse. It may also the take the form of coercion to secure a woman's consent to labor induction, cesarean, or another form of medical intervention; health care providers sometimes threaten to seek a court order or make a child welfare report if a woman declines the intervention; or woman who has previ-

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discourse around Black maternal crisis often replaces actual political labor to improve the lives of Black mothers and children. Cole writes, "The contemporary urgency around elucidating the dilemma of black maternal and infant death . . . has in many ways become a means of capitalizing on the spectacle of black suffering and death. Specifically, it has become efficacious and newsworthy to center research and programming on black mortality." Haile Eshe Cole, *Reproduction on Display: Black Maternal Mortality and the Newest Case for National Action*, 9 J. OF THE MOTHERHOOD INITIATIVE FOR RSCH. AND COMMUNITY INVOLVEMENT 89, 93 (2018).

[28] Maria Trent et al., *The Impact of Racism on Child and Adolescent Health*, 144 PEDIATRICS, no. 2, 2019, at 1, https://pediatrics.aappublications.org/content/pediatrics/144/2/e20191765.full.pdf [https://perma.cc/M4BB-YWNP].

[29] In 2018, the federal government passed the Preventing Maternal Deaths Act, which provided federal grants to states that actively investigate maternal deaths. *See* Katy Kozhimannil, et al., *Beyond the Preventing Maternal Deaths Act: Implementation and Further Policy Change*, HEALTH AFFAIRS (Feb. 4, 2019) https://www.healthaffairs.org/do/10.1377/hblog20190130.914004/full/ [https://perma.cc/8DRQ-25G3]. In 2019, fifty-seven members of Congress joined the newly formed Black Maternal Health Caucus. *See* Rachel Frazin, *Dem Lawmakers Form Black Maternal Health Caucus*, THE HILL (Apr. 9, 2019) https://thehill.com/homenews/house/438004-dem-reps-form-black-maternal-health-caucus [https://perma.cc/VG25-43B6]. Illinois senator Dick Durbin and Representative Robin Kelly introduced the Mothers and Offspring Mortality and Morbidity Awareness Act (MOMMA Act), which would establish regional centers to address cultural competency in health care delivery and extend Medicaid coverage to a full year postpartum. *See* Mothers and Offspring Mortality and Morbidity Awareness Act or the MOMMA's Act, H.R. 1897, 116th Cong. (2019-2020). A few days before Mother's Day in 2019, Senator Cory Booker and Representative Ayanna Pressley introduced a bill called the Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Services (MOMMIES) Act, which extended Medicaid coverage—which was required to last sixty days following birth, though some states had longer periods of coverage—for postpartum women to a year after giving birth and explicitly supported services including doulas and midwives. *See* MOMMIES Act, S. 1343, 116th Cong. (2019-2020).

> ously delivered by cesarean may be coerced into an unwanted and medically unnecessary repeat cesarean due to hospital-wide restrictions on VBAC [vaginal birth after cesarean].[30]

Kukura's perspective emphasizes the central role of the hospital in perpetrating obstetric violence, even as the form of that violence can vary.[31] Kimberly Sears Allers describes obstetric violence similarly as "stories of insults, harassment, disregard for pain and nonconsensual touching during OB/GYN exams and childbirth," yet she underscores that this violence spans the perinatal period and includes "the denial of treatment, verbal humiliations, invasive practices, or a disregard for pain, as well as a lack of privacy during vaginal exams, unnecessary use of medication and sexual assault."[32] Indeed, exposing how medicalized violence is ordinary and routine, particularly for Black women, has become a touchstone of the reproductive justice movement.

Much of the attention to maternal health—made possible by reproductive justice feminists' activism—has centered on the hospital as a key site of violence, of deadly outcomes for Black women. This is unsurprising in a country where the vast majority of births unfold at hospitals.[33] At times, there has been a sustained attention to providers' failure to listen to Black mothers, leading some to argue that the key to eradicating the racial disparity in maternal death is more Black providers,[34] or training current providers in

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[30] Elizabeth Kukura, *Revisiting Roe to Advance Reproductive Justice for Childbearing Women*, 94 Notre Dame L. Rev. 20, 22 (2018).

[31] *See* Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 47 Reprod. Health Matters 56, 57 (2016) (noting "the existing US research suggests that women experience significant pressure and loss of autonomy in maternity care. Roth et al surveyed birth workers (including doulas, childbirth educators, and labour and delivery nurses) and found that more than half had witnessed a physician engage in a procedure explicitly against a woman's will, and nearly two-thirds had witnessed providers "occasionally" or "often" engage in procedures without giving a woman a choice or time to consider the procedure") (citing Louise Marie Roth et al., Maternity Support Survey, A Report on the Cross-National Survey of Doulas, Childbirth Educators and Labor and Delivery Nurses in the United States and Canada 36 (2014), https://maternitysurvey.files.wordpress.com/2014/07/mss-report-5-1-14-final.pdf [https://perma.cc/U5EK-8SAM]).

[32] Kimberly Sears Allers, *Obstetric Violence is a Real Problem: Evelyn Yang's Experience is Just One Example*, Wash. Post (Feb. 6, 2020), https://www.washingtonpost.com/lifestyle/2020/02/06/obstetric-violence-is-real-problem-evelyn-yangs-experience-is-just-one-example/ [https://perma.cc/9C2E-H3E2].

[33] The collaboration between law and institutionalized medicine marks birthing in non-medical locations, particularly homes, as risky and even criminal, with the exception of the long period of COVID-19 that, as I argue elsewhere, remade the meaning of home birth. *See* Jennifer C. Nash, *Home is Where the Birth Is: Race, Risk, and Labor During COVID-19* Yale J. Law Fem. 32.2 (forthcoming).

[34] For coverage of the lack of Black providers, *see A Key to Black Infant Survival? Black Doctors*, Nat. Pub. Radio (Sept. 18, 2020), https://www.npr.org/transcripts/913718630 [https://perma.cc/NZH3-6RZA]; Maria Aspan, *The Lack of Black Doctors is Killing Black Babies, New Study Finds*, Fortune (Aug. 20, 2020), https://fortune.com/2020/08/20/black-doctors-mortality-rate-newborns/ [https://perma.cc/R83A-3KES]; Tressie McMillan Cottom, *I Was Pregnant and in Crisis. All the Doctors and Nurses Saw*

the deadly outcomes of implicit bias and medical racism.[35] Leslie Farrington writes, "Black mothers are often not listened to . . . Deaths and severe complications related to pregnancy and childbirth are the tip of the iceberg of medical harm experienced by Black birthing people, from rushed prenatal visits to unnecessary and unwanted cesarean births. . . ."[36] A ProPublica investigation found that "black serving" hospitals are more likely to have patients facing severe complications, and analysis of two years of hospital data found "the same broad pattern identified in previous studies—that women who hemorrhage at disproportionately black-serving hospitals are far more likely to wind up with severe complications, from hysterectomies, which are more directly related to hemorrhage, to pulmonary embolisms, which can be indirectly related."[37] One obstetrician-gynecologist noted in reaction to the findings, "The common thread is that when black women expressed concern about their symptoms, clinicians were more delayed and seemed to believe them less . . . It's forced me to think more deeply about my own approach. There is a very fine line between clinical intuition and unconscious bias."[38]

The material consequences of bias—and of the embodied and epidemiological racial stress that Black mothers literally carry, which Elaine Geronimous famously termed "weathering"[39]—are largely described as

Was an Incompetent Black Woman, TIME (Jan. 8, 2019), https://time.com/5494404/tressie-mcmillan-cottom-thick-pregnancy-competent/ [https://perma.cc/S3V9-HQKR] ("What so many black women know is what I learned as I sat at the end of a hallway with a dead baby in my arms. The networks of capital, be they polities or organizations, work most efficiently when your lowest status characteristic is assumed. And once these gears are in motion, you can never be competent enough to save your own life."); *Mortality Rate for Black Babies is Cut Dramatically When Black Doctors Care for Them After Birth, Researchers Say*, WASH. POST (Jan. 8, 2021), https://www.washingtonpost.com/health/black-baby-death-rate-cut-by-black-doctors/2021/01/08/e9f0f850-238a-11eb-952e-0c475972cfc0_story.html [https://perma.cc/U9AX-P5KZ].

[35] Elizabeth Chuck, *How Training Doctors in Implicit Bias Could Save the Lives of Black Mothers*, NBC NEWS (May 11, 2018), https://www.nbcnews.com/news/us-news/how-training-doctors-implicit-bias-could-save-lives-black-mothers-n873036 [https://perma.cc/7FEM-ATSX].

[36] Leslie Farrington, *How the CDC and Others are Failing Black Women During Childbirth*, STAT NEWS (Sept. 18, 2020), https://www.statnews.com/2020/09/18/how-the-cdc-and-others-are-failing-black-women-during-childbirth/ [https://perma.cc/YTE9-TQ4R].

[37] Annie Waldman, *How Hospitals Are Failing Black Mothers*, PROPUBLICA (Dec. 27, 2017), https://www.propublica.org/article/how-hospitals-are-failing-black-mothers [https://perma.cc/BT4B-WFEQ].

[38] Amy Roeder, *America is Failing Its Black Mothers*, HARV. PUB. HEALTH (2019), https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/ [https://perma.cc/Q8CA-Q4LD].

[39] For signature articles where Geronimous develops weathering, see Arline T. Geronimus, *On Teenage Childbearing and Neonatal Mortality in the United States*, 13 POP. AND DEV. REV. , no. 2, 245 (1987); Arline T. Geronimus, *The Weathering Hypothesis and the Health of African American Women and Infants: Evidence and Speculations*, 2 ETHNICITY & DISEASE 207 (1992); Arline T. Geronimus et al., *'Weathering' and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States*, 96 AM. J. OF PUB. HEALTH 826 (2006); Arline T. Geronimus et al., *Do US Black Women Experience Stress-Related Accelerated Biological Aging*?, 21 HUM. NATURE 19 (2010).

experienced at hospitals and take myriad forms, including the racial disparities in C-sections and the denial of pain medication to postpartum birthing Black people.[40] Emily Bobrow writes, "In obstetrics, for example, hospitals regularly tell Black women they are less likely than white women to have a successful vaginal delivery after a C-section, regardless of other details. The accumulation of all of this is that Black people get less care."[41] Here, it is hospitals that are the scene of intrusive violence, where the manifestation of anti-Black misogyny is brutally felt by Black birthing bodies.

If the hospital is all too often an intrusive presence, there is also increasing attention to the non-care Black mothers experience in hospitals. Serena Williams' famous account of her experience with medical non-responsiveness to her postpartum health is emblematic of this, an account which foregrounds how even affluent celebrity Black women are subject to medical neglect. In a 2018 article in *Vogue Magazine*, Rob Haskell reports:

> The next day, while recovering in the hospital, Serena suddenly felt short of breath. Because of her history of blood clots, and because she was off her daily anticoagulant regimen due to the recent surgery, she immediately assumed she was having another pulmonary embolism. (Serena lives in fear of blood clots.) She walked out of the hospital room so her mother wouldn't worry and told the nearest nurse, between gasps, that she needed a CT scan with contrast and IV heparin (a blood thinner) right away. The nurse thought her pain medicine might be making her confused. But Serena insisted, and soon enough a doctor was performing an ultrasound of her legs. "I was like, a Doppler? I told you, I need a CT scan and a heparin drip," she remembers telling the team. The ultrasound revealed nothing, so they sent her for the CT, and sure enough, several small blood clots had settled in her lungs. Minutes later she was on the drip. "I was like, listen to Dr. Williams!"[42]

I quote this at length because it captures the profound neglect Williams experienced: a refusal to listen to her symptoms, to trust her reports of her own

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[40] *See* Lisa Rapaport, *Black, Hispanic Mothers Report More Pain After Delivery but Get Less Pain Medication*, REUTERS (Nov. 12, 2019), https://www.reuters.com/article/us-health-postpartum-pain/black-hispanic-mothers-report-more-pain-after-delivery-but-get-less-pain-medication-idUSKBN1XM2R4 [https://perma.cc/J7ZF-5EDV]. This extends to labor when Black women are the least likely to receive epidurals for pain management. *See* Laurent G. Glance et al., *Racial Differences in the Use of Epidural Analgesia for Labor,* 106 ANESTHESIOLOGY 19, 24 (2007), https://pubs.asahq.org/anesthesiology/article/106/1/19/8893/Racial-Differences-in-the-Use-of-Epidural [https://perma.cc/A94C-YDYF] ("A number of different factors may account for the observed differences in epidural use across different racial and ethnic groups. These factors included differences in pain perception and patient preferences, and provider bias.").

[41] Bobrow, *supra* note 2.

[42] Rob Haskell, *Serena Williams on Motherhood, Marriage, and Making Her Comeback*, VOGUE (Jan. 10, 2018), https://www.vogue.com/article/serena-williams-vogue-cover-interview-february-2018 [https://perma.cc/W28L-LLJW].

body, and to hear her concerns about her medical history. This neglect could have deadly consequences, even for a celebrity like Williams, as scholars emphasize that class status is no immunization from the persistence of medical violence.[43] Tressie McMillan Cottom reflects on Williams' experience and asks:

> In the wealthiest nation in the world, black women are dying in childbirth at rates comparable to those in poorer, colonized nations. The CDC says that black women are 243 percent more likely to die from pregnancy or childbirth-related causes than are white women. Medical doctors surely know about these disparities, right? Why, then, would a global superstar have to intervene so directly in her own postnatal care, and what does that say about how poorer, average black women are treated when they give birth?[44]

Celebrity cases like Williams' only underscore the violence of the hospital, the sense that it is ground-zero of obstetric violence, and the sense that providers approach Black birthing patients with distrust, neglect, and an unwillingness to listen.

But there is another perspective on the hospital, one carefully attuned to what happens when hospitals disappear, when the scene of violence is not inside the hospital but in its absence. Washington, D.C. has been described as the quintessential "maternal care desert," a race-neutral term that obscures that it is a desert for Black birthing people and a desert that particularly affects the District's Southeast quadrant and its primarily Black population. Kayla Randall and Kaarin Vembar emphatically note that the District is "one of the worst places in the United States, and in the developed world, to deliver a child,"[45] and in 2015, Save the Children described Ward

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[43] *See* Nina Martin, *Nothing Protects Black Women From Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 7, 2017), https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth [https://perma.cc/MLL6-9ASG]; Linda Villarosa reports:

> The study, conducted by four researchers at the C.D.C. — Kenneth Schoendorf, Carol Hogue, Joel Kleinman and Diane Rowley — mined a database of close to a million previously unavailable linked birth and death certificates and found that infants born to college-educated black parents were twice as likely to die as infants born to similarly educated white parents. In 72 percent of the cases, low birth weight was to blame. I was so surprised and skeptical that I peppered him with the kinds of questions about medical research that he encouraged us to ask in his course. Mainly I wanted to know *why*. "No one knows," he told me, "but this might have something to do with stress.".

Villarosa, *supra* note 26.

[44] Cottom, *supra* note 34.

[45] Kayla Randall & Kaaarin Vembar, *Women in D.C. Face Obstacles at Every Step of Pregnancy and Childbirth,* WASH. CITY PAPER (Aug. 30, 2018), https://washingtoncitypaper.com/article/184340/women-in-dc-face-obstacles-at-every-step-of-pregnancy-and-childbirth/ [https://perma.cc/49XZ-GQEV]. The authors note:

8—which is 92% Black—as a place where "[infants] are 10 times more likely to die than children in Ward 3, Washington's affluent northwest."[46]

In December 2017, a few days after requesting millions of dollars from the District, United Medical Center—the only hospital east of the Anacostia River (and the only public hospital in the District)—decided to close its obstetrics unit.[47] The closest hospitals—Howard University Hospital, Providence Hospital, and Prince George's Hospital Center—are all at least a twenty-minute drive from the District's Southeast quadrant, something that became particularly visible when, in the fall of 2019, Shaquana Bates delivered a stillborn and nearly died when an ambulance took an hour to transport her to a DC hospital.[48] Councilman Vince Gray said of the hospital's initial closing by regulators earlier that year, "I am incredibly concerned that residents on the East End of the District no longer have the option to have their babies delivered at an East End hospital."[49]

The closure of United Medical Center's maternity ward was a complicated story. In 2017, the D.C. Department of Health (DOH) ordered the hospital to stop all deliveries and prenatal care because of systemic

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Black women are three to four times more likely than white women to die from childbirth in the U.S. The District is a case in point. Dr. Roger A. Mitchell, D.C.'s chief medical examiner, testified at a December public hearing on maternal mortality that 75 percent of the maternal deaths D.C. recorded between 2014 and 2016 were black women.

[46] Miriam Zoila Pérez, *A Maternity Care Desert Threatens Lower Income Women in Washington, D.C.*, COLORLINES (Sept. 28, 2017), https://www.colorlines.com/articles/maternity-care-desert-threatens-lower-income-women-washington-dc [https://perma.cc/B4YM-XXEQ].

[47] *See* Peter Jamison, *Nursery and Delivery Rooms at D.C.'s Public Hospital Will Not Reopen*, WASH. POST (Dec. 13, 2017), https://www.washingtonpost.com/local/dc-politics/nursery-and-delivery-rooms-at-dcs-public-hospital-will-not-reopen/2017/12/13/cec40a42-e038-11e7-8679-a9728984779c_story.html [https://perma.cc/2CEC-6SWJ].

[48] *See* Amanda Michelle Gomez, *She Had a Stillborn Baby. She Faults an Ambulance Delay*, WASH. CITY PAPER (Oct. 21, 2019), https://washingtoncitypaper.com/article/177988/she-had-a-stillborn-baby-she-faults-an-ambulance-delay/ [https://perma.cc/Y33C-FJJ2]. Gomez writes:

> When two ambulances arrived, 31 minutes after Bates' mother first called for help, the first responders debated which vehicle would transport her, she says, making every second feel like lost time. Bates recounts other instances that felt this way: The ambulance stopped twice because the driver said the back door was open, first responders sounded like they didn't know where to go when they arrived to the hospital. The ambulance departed for the hospital at 10:02 p.m. and arrived at 10:23 p.m. Bates delivered a stillborn baby. The obstetrician who delivered Daymarion said Bates too was at risk—she could have died due to blood loss. She received two blood transfusions, and stayed in the hospital for seven days after the birth. The hospital let Bates keep her baby in a refrigerated crib in her room. "If the ambulance came on time, I don't think I would be going through this," says Bates. "The only support I really had was the caseworker from Washington Hospital."

[49] Fenit Nirappil, *D.C. Shuts Down Obstetrics Ward at United Medical Center for 90 Days*, WASH. POST (Aug. 8. 2017), https://www.washingtonpost.com/local/dc-politics/dc-shuts-down-obstetrics-ward-at-united-medical-center-for-90-days/2017/08/08/31c359ae-7c52-11e7-9d08-b79f191668ed_story.html [https://perma.cc/PMG4-FGE3].

"deficiencies."[50] According to reports, the hospital staff failed to "take critical steps to prevent the transmission of HIV from an infected mother to her newborn, such as delivering by Caesarean section or treating the infant shortly after birth with antiretroviral medication."[51] A pregnant patient with breathing difficulty and a history of pre-eclampsia was not properly monitored, and obstetricians failed to physically screen a newborn at the proper time after birth.[52] DOH Director LaQuandra Nesbitt noted, "We found things that led us to decisions to restrict the hospital's license to not provide scheduled deliveries and the subsequent newborn nursery services that would occur."[53] Thus United Medical Center, while present in the community, was hardly serving its community members with adequate care; in fact, its presence was marked by significant failures of care with material consequences. Yet the announcement of the closure of the maternity ward for good was met with tremendous sadness and political unrest. Ebony Marcelle, the director of midwifery at DC's Community of Hope's Family Health and Birth Center, said:

> It's a huge issue that we don't have a hospital east of the river. UMC wasn't perfect and they definitely have their drama. I get it. However, for me, a lot of times it was like a gateway for my women in Ward 8. It would be a start sometimes for them. It takes two hours to get across town on a bus to Northwest.[54]

While the story of the maternal medical desert is often reported as one that particularly impacts Black women living in urban centers like Washington, D.C.—and particularly hyper-segregated urban centers (like Chicago and D.C.)—this is not exclusively a story about the metropole and Black women's abandonment by the hospital in urban landscapes. Indeed, maternal

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[50] Peter Jamison & Fenit Nirappil, *Dangerous Mistakes Led to Shutdown of United Medical Center Obstetrics Ward,* WASH. POST. (Aug. 14, 2017), https://www.washingtonpost.com/local/dc-politics/dangerous-mistakes-led-to-shutdown-of-united-medical-center-obstetrics-ward/2017/08/14/5639006a-8114-11e7-b359-15a3617c767b_story.html archived at [https://perma.cc/2FK2-FMZY].

[51] *Id.*

[52] *Id.*

[53] *Id.*

[54] Randall & Vembar, *supra* note 45. As of the time of writing this article, the hospital is slated to close in January 2023. This decision has also generated substantial controversy. Pat Garofalo reports:

> UMC is currently the only hospital in Washington that is not in the city's northwest quadrant—which is both its whitest and richest. The city is grappling with the effects of widespread gentrification and rapidly changing demographics. By one measure, it is the fastest gentrifying city in the country, and in the top four for most black residents displaced. The population UMC serves is majority black, the poorest in the city, and disproportionately composed of Medicaid and Medicare patients.
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> Pat Garofalo, *Inside the Fight over the Last Hospital in D.C.'s Poorest Neighborhood*, TALK POVERTY (May 28, 2019), https://talkpoverty.org/2019/05/28/umc-dc-hospital-closure/ [https://perma.cc/24VB-AW5F].

medical deserts mark rural areas where OBGYN practitioners are scarce,[55] and where maternity wards have closed at staggering numbers.[56] One North Carolina-based journalist reminded readers that "[u]rban or rural, black lives in NC [are] cut short almost before they begin."[57] Indeed, the term "rural" often reads as race-neutral, or even white, thus hiding the experiences of Black rural women. As Katy B. Kozhimannil argues, the term "rural" is often coded as white in America, yet 1 in 5 rural Americans is a person of color, and the loss of rural maternity wards disproportionately affects counties with Black residents.[58] Thus, what unites Black women in the metropole and in rural contexts is the disappearance of medical institutions serving Black perinatal bodies.

We might think of these competing conceptions of the hospital—overly present and wholly absent—as emblematic of the complex relationship of

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[55] *See* Linda Marsa, *Labor Pains: the OB-GYN Shortage*, AAMCNEWS (Nov. 15, 2018), https://www.aamc.org/news-insights/labor-pains-ob-gyn-shortage [https://perma.cc/R4A5-5TJS] ("The growing OB-GYN shortage is mostly a matter of demand exceeding supply. In recent decades, the number of U.S. women over age 18 has increased by 33 million—yet OB-GYN first-year residency positions grew by less than 200 between 1992 and 2016. In addition, many OB-GYNs are nearing retirement: their average age is 51, and they tend to retire beginning at 59. Some may consider leaving in part because of their specialty's high likelihood of being sued. In fact, nearly two out of three OB-GYNs face legal action at some point, the highest rate of all specialties, according to a 2018 report.") (citing Press Release, Doximity, New Research Details Risk of National OB-GYN Shortage (July 20, 2017) (citing JOSÉ R. GUARDADO, AM. MED. ASSOC'N, MEDICAL LIABILITY CLAIM FREQUENCY AMONG U.S. PHYSICIANS (2017)). The ACOG reports that half of US counties do not have even one OBGYN. *See* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 19.

[56] *See* Bram Sable-Smith, *Pregnant Women in Rural Areas Increasingly Travel to Give Birth*, HARVEST PUB. MEDIA (Sept. 27, 2017), https://www.harvestpublicmedia.org/post/pregnant-women-rural-areas-increasingly-travel-give-birth [https://perma.cc/Z4UR-SJ6N]; Katie King, *Rural Women Must Often Travel Great Distances for Care*, MOD. HEALTHCARE (Sept. 5, 2018), https://www.modernhealthcare.com/article/20180905/NEWS/180909979/rural-women-must-often-travel-great-distances-for-care [https://perma.cc/K8D3-9RCN]; Dina Fine Maron, *Pregnant Women Often Have to Travel an Hour or More to Deliver in Rural America*, SCIENTIFIC AMERICAN (Feb. 16, 2017), *reprinted in* STAT (Feb. 16, 2017), https://www.statnews.com/2017/02/16/pregnant-women-rural-america/ [https://perma.cc/L9TW-BXUR] (Writing about Alabama, Maron notes, "Such extreme access problems lead to difficult decisions. Some women in Alabama preemptively choose caesarean section births because they fear they will not make it to the hospital in time, says Dale Quinney, executive director of the Alabama Rural Health Association. Although there have been no studies proving it, Quinney believes the access issue helps explain why his state has one of the country's highest caesarean rates—35.4 percent of its births in 2015. (The national average was 32 percent that year.)" (citing Joyce A. Martin et al., U.S. Dep't Health & Human Serv., NCHS Data Brief No. 258, Births in the United States, 2015 (2016), https://www.cdc.gov/nchs/data/databriefs/db258.pdf [https://perma.cc/MW7H-QXKL]). In 2017, 54% of rural counties in the US had no hospital obstetrics.

[57] Lynn Bonner, *Urban or Rural, Black Lives in NC Cut Short Almost Before They Begin*, CHARLOTTE POST (Jan. 30, 2020), http://www.thecharlottepost.com/news/2020/01/30/local-state/urban-or-rural-black-lives-in-nc-cut-short-almost-before-they-begin/ [https://perma.cc/E7RG-D9CB].

[58] *See* Katy B. Kozhimannil, *Role of Racial and Geographical Bias in Rural Maternity Care*, AJMC (Sept. 5, 2017), https://www.ajmc.com/view/role-of-racial-and-geographical-bias-in-rural-maternity-care [https://perma.cc/J5VZ-FUU2].

Black women to institutions. At once, reproductive justice advocates contend that Black mothers *should* have access to institutional medicine, even as they underscore that institutional medicine is the site of violence. In many ways, this conundrum is one that critical race scholars have contended with for decades, often around the criminal justice system. Randall Kennedy[59] famously argues that the criminal justice system under-protects Black people, even as scholars like Michelle Alexander[60] point to the over-presence of the criminal justice system in shaping Black life. Reginald Dwayne Betts poignantly describes this dilemma:

> I know that American prisons do little to address violence. If anything, they exacerbate it. If my friends walk out of prison changed from the boys who walked in, it will be because they've fought with the system—with themselves and sometimes with the men around them—to be different. Most violent crimes go unsolved, and the pain they cause is nearly always unresolved. And those who are convicted—many, maybe all—do far too much time in prison. And yet, I imagine what I would do if the Maryland Parole Commission contacted my mother, informing her that the man who assaulted her is eligible for parole. I'm certain I'd write a letter explaining how one morning my mother didn't go to work because she was in a hospital; tell the board that the memory of a gun pointed at her head has never left; explain how when I came home, my mother told me the story. Some violence changes everything.[61]

This is perhaps the paradox of institutionality, one that is even more profound for reproductive justice advocates who seek "More Life" for Black mothers and their children, and who want at once the reformed hospital and something that Michell Miller calls "obstetric abolitionism."[62] I point to this paradox not to critique the reproductive justice movement, which I see as profoundly generative in the labor it has performed on behalf of Black women's freedom. Instead, I point to this paradox to suggest an opportunity to clarify the political desires of this profoundly significant social movement, to make clear precisely what kinds of change we desire and seek and

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[59] *See* RANDALL KENNEDY, RACE, CRIME & THE LAW 29 (1997) ("Deliberately withholding protection against criminality (or conduct that should be deemed criminal) is one of the most destructive forms of oppression that has been visited upon African-Americans.").

[60] *See* MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS 2 (2010) ("[W]e use our criminal justice system to label people of color 'criminals' and then engage in all the practices [of discrimination, exclusion, and social contempt] we supposedly left behind.").

[61] Reginald Dwayne Betts, *Kamala Harris, Mass Incarceration, and Me*, N.Y. TIMES (Oct. 20, 2020), https://www.nytimes.com/2020/10/20/magazine/kamala-harris-crime-prison.html [https://perma.cc/UNK9-UAUE].

[62] Personal conversation with Michell Miller, PhD Candidate, Performance Studies, Northwestern University (Apr. 7, 2020).

where we might isolate the key of our push toward eliminating obstetric violence and ensuring birth freedom.

II. The Racial Politics of Perinatal Credentials

While reproductive justice advocates have focused on the hospital's intrusive presence or wholesale absence as indicative of the workings of obstetric violence, I argue that this perspective misses something crucial: the hospital is merely *one* dense node in a larger web of legal and medical actors that produce and uphold standards shoring up proximity to institutional medicine as the preeminent form of care. These standards denigrate both providers and patients who operate outside of these structures, deeming them risky, dangerous, and at times, criminal. In other words, while the hospital is only one site of violence, it enacts, reflects, and performs a set of standards that prop up institutionalized medicine as the appropriately risk-mitigating site for perinatal care. Those standards are produced both by institutionalized medicine, including organizations like the American Medical Association, and by law in its efforts to regulate myriad forms of birth-work in the name of patient safety and standardization. Indeed, the question of standardization goes to the heart of the complex politics of institutionality that haunt Black feminist thought. On the one hand, standards can ensure that Black mothers receive adequate care and that providers follow checklists designed to minimize discretion and maximize the provision of care. On the other hand, standards can perpetuate elitism, secure the privilege of the most conventionally educated and credentialized, and effectively undermine or discredit training secured through experience rather than through traditional schooling.

Indeed, law and medicine have collaborated to create standards around much of perinatal caregiving, including the lactation industry and midwifery. I argue that these standards have historically worked to punish, regulate, and even criminalize Black women providers and patients, particularly those who approach perinatal life with a critique of conventional medicine, or with an awareness of statistics revealing how deadly institutionalized medicine can be for Black birthing people.[63] The hospital is part of this story, of course, but the forces that operate to uphold seemingly neutral standards in

[63] I take this up more in my earlier work. *See* Jennifer C. Nash, *Birthing Black Mothers: Birth Work and the Making of Black Maternal Political Subjects*, 47 Women's Stud. Q. 29, 29–50 (2019). *See also* Helena Andrews-Dyer, *This Isn't Another Horror Story About Black Motherhood*, Wash. Post (Sept. 4, 2019), https://www.washingtonpost.com/graphics/2019/lifestyle/black-motherhood/ [https://perma.cc/JWY5-99WC] ("Forget putting your feet up or sticking your head in the sand. This isn't an option for black women staring down a plus sign. These days your pregnancy must be 'woke,' 10 months filled with research and study and planning. As a black woman, it's not enough to 'stay hydrated,' make your prenatal appointments and curate the perfect nursery on Pinterest. There are studies to digest, articles forwarded by your best friend on C-section rates to read, summits to attend on combating implicit bias, and doctors to screen for implicit bias. It is exhausting work. And I need a break.").

the name of safety or standardization are far greater than the hospital. In reading the hospital as one node in a larger network of regulatory actors that shore up hierarchies that operate in the name of care but produce rampant non-care, I ask: what if we think of institutionalized medicine—including but not limited to the hospital—not merely as a site that polices and injures Black women's bodies through its presence and absence, but as a location that produces wholesale topographies of non-care taking myriad forms, including maternal care deserts, the denial of epidurals, long rides to secure prenatal care, and unwanted C-sections.

In this section, I argue that these geographies are crucially made through systems of credentialization and standardization, medical and legal hierarchies which assign risk to certain providers and patients, and non-risk to others. As I show here, Black providers and patients are regularly marked as problematic, pathological, dangerous, and risk-prone, even as they collectively labor to secure Black maternal life, particularly in the face of a new cultural awareness of staggering Black maternal and infant mortality rates. In foregrounding the construction of Black patients—particularly Black perinatal patients—as pathological, I draw on Khiara M. Bridges' work. Bridges' ethnographic study of a New York City public hospital and the perinatal patients it serves reveals that Black perinatal patients are often constructed as "wily." This notion of Black perinatal flesh as wily is a profound "controlling image"[64] which constructs the "wily patient's pregnant body . . . not . . . as a symbol of infinite possibility, joy, or self-fulfillment—a reading that may only be reserved for the non-poor. . . . [T]he (poor) wily patient's pregnancy is realized as the event that makes the welfare queen possible, the condition that makes the entire welfare apparatus necessary."[65] As Tessie Cottom describes in her own account of medical racism and obstetric violence, "When the medical profession systematically denies the existence of black women's pain, underdiagnoses our pain, refuses to alleviate or treat our pain, healthcare marks us as incompetent bureaucratic subjects. Then it serves us accordingly."[66]

As a way of thinking about the labor of institutional medicine and its ongoing practice of marking—and unmarking—certain actors as safe, I turn to two ongoing legal and medical debates that far exceed the space of the hospital and fundamentally touch on Black maternal and infant survival: (1) debates about midwifery and (2) debates about lactation consultants. I have

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[64] "Controlling image" is Patricia Hill Collins's term developed in her foundational BLACK FEMINIST THOUGHT (1990).

[65] KHIARA BRIDGES, REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION 227 (2008).

[66] TRESSIE MCMILLAN COTTOM, THICK: AND OTHER ESSAYS 86 (2019). On the discrimination that Black medical providers experience, *see* Yuki Noguchi, *To Be Young, A Doctor and Black: Overcoming Racial Barriers in Medical Training,* NPR (Jul. 1, 2020), https://www.npr.org/sections/health-shots/2020/07/01/880373604/to-be-young-a-doctor-and-black-overcoming-racial-barriers-in-medical-training [https://perma.cc/HK4M-UQJG].

chosen these two sites because both are central to Black infant and maternal health, and both too often fall out of reproductive justice conversations focused on the hospital as the site of violence. The midwifery model of care, for example, has been shown to yield far fewer C-sections,[67] a statistic particularly important for Black mothers who are both more likely than their white counterparts to receive C-sections in hospitals and more likely to die from postnatal complications.[68] In the case of midwifery, home births have been hailed by some Black birthworkers—particularly during COVID-19—as an option Black birthing people should consider to avoid the deadly outcomes associated with the hospital. Yet the legal and medical regulation of midwifery make that decision largely impossible, compelling patients to interface with institutionalized medicine in order to avoid pathologization.

In the case of the lactation industry, there has been both an increased state and public health investment in promoting breastfeeding and a particular investment in supporting Black breastfeeding, given a new cultural attention to a racial gap in breastfeeding rates.[69] Chelsea O. McKinney and her colleagues found that 61% of Black mothers initiated breastfeeding compared to 78% of white mothers.[70] This has led some scholars and activists to argue that "the large disparity in breastfeeding rates between black women and women of other races and ethnicities means that breastfeeding-related programs and legislation must be examined from an anti-essentialist, intersectionality perspective."[71] While I have offered critiques of what has become a near-mandate to breastfeed (a mandate that is particularly enforced to constrain poor women's infant-feeding choices), here I flag how breastfeeding is at once hailed as a crucial technology of supporting Black

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[67] *See* Linda Carroll, *Fewer C-Sections When Low-Risk Deliveries Handled by Midwives*, REUTERS (Oct. 10, 2019), https://www.reuters.com/article/us-health-birth-midwives/fewer-c-sections-when-low-risk-deliveries-handled-by-midwives-idUSKBN1WP38D [https://perma.cc/7QSJ-GNZZ].

[68] *See* Marco Huesch & Jason N. Doctor, *Factors Associated with Increased Cesarean Risk Among African American Women: Evidence from California*, 105(5) AM. J. PUB. HEALTH 956, 959 (2015) (noting main finding that "African American women without previous cesarean were significantly more likely to deliver by primary cesarean . . . than women of other race/ethnicity . . ."); Press Release, Centers for Disease Control, Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths (Sept. 5, 2019), https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html [https://perma.cc/6MHY-RBYK] (noting "Black . . . women are two to three times more likely to die from pregnancy-related causes than white women . . ."). C-sections can generate many of these complications, including hemorrhage, infection, and blood clots.

[69] Philadelphia's Department of Public Health, for example, has a campaign to promote Black breastfeeding. *See* Nina Feldman, *To Promote Breastfeeding Among Women of Color, Philly Campaign Features Black Moms,* WHYY (Aug. 29, 2018), https://whyy.org/articles/to-promote-breastfeeding-among-women-of-color-philly-campaign-features-black-moms/ [https://perma.cc/5T7B-WB6F].

[70] Chelsea O. McKinney et al., *Racial and Ethnic Differences in Breastfeeding*, 138 PEDIATRICS, no. 2, at 1, 2016, https://pubmed.ncbi.nlm.nih.gov/27405771/ [https://perma.cc/MXX2-EM6T].

[71] Jennifer Bernstein & Lainie Rutkow, *Hospital Breastfeeding Laws in the US: Paternalism of Empowerment*, 44 UNIV. BALT. L. REV. 163, 172 (2015).

life *and* access to lactation support remains challenging for many Black birthing people. In the case of both midwives and lactation consultants, law and medicine collaborate to create a landscape marked by non-care and non-access even as that non-care and non-access is experienced, inhabited, and embodied differently depending on location.

Midwifery

A patchwork of state laws produces uneven statuses for midwives across the United States. Midwives whose practice most resembles conventional medical care—certified nurse midwives (CNM)—are allowed to practice in all fifty states.[72] CNMs are master's educated nurses who are certified by the American Midwifery Certification Board.[73] They generally perform deliveries in hospitals and have access to licensure and prescription in all fifty states. If CNMs operate in proximity to law and medicine, the certified professional midwife (CPM)—sometimes called a "direct entry midwife"[74] or denigrated as a "lay midwife"[75]—operates differently. CPMs generally practice in non-hospital settings, including in birthing centers and at home births.[76] The CPM's qualifications include a high school diploma and demonstration of competency in specific areas of knowledge and skills.[77] Their certification is issued through the North American Registry of Midwives.[78] In some states—like Illinois—CPMs remain unlicensed, rendering home birth an unregulated, and, some argue, even "underground," practice.[79] Some states have had spirited debates about whether to recognize and license CPMs. When South Dakota considered licensure legislation, Dr. Robert J. Summerer, president of the South Dakota State Medical Association, de-

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[72] *See* American Midwifery Certification Board, Why AMCB Certification? https://www.amcbmidwife.org/amcb-certification/why-amcb-certification- [https://perma.cc/6FDK-JUXD].

[73] *See id.*

[74] *See* Midwives Alliance of North America, Types of Midwives, https://mana.org/about-midwives/types-of-midwife [https://perma.cc/CN4Z-ZQNL] (defining "direct-entry midwives" as midwives who "do not have a nursing education as a prerequisite for midwifery education" and listing "Certified Professional Midwife" as an example "direct-entry midwife").

[75] *See* Amy Tuteur, *Why Is American Home Birth So Dangerous?*, N.Y. Times (May 1, 2016), https://www.nytimes.com/2016/05/01/opinion/sunday/why-is-american-home-birth-so-dangerous.html [https://perma.cc/Y84P-2JG5] (noting CPMs used to be called "lay midwives").

[76] *See Labor and Delivery: Types of Midwives*, Healthline Parenthood, https://www.healthline.com/health/pregnancy/intrapartum-care-midwife [https://perma.cc/BHG7-BCJE] (noting CPMs "work[ ] independently with women delivering at home or in birth centers").

[77] *See* American Midwifery Certification Board, *supra* note 72.

[78] *See id.*

[79] Dana Vollmer, *Illinois Rules Leave Mothers With Little Access to Experienced Midwives*, NPR Illinois (May 8, 2019), https://www.nprillinois.org/post/illinois-rules-leave-mothers-little-access-experienced-midwives#stream/0 [https://perma.cc/4P7X-2ULR].

clared, "[i]t is very clear that [CPMs] training is inadequate and it's putting two people at risk: the mother and the child."[80] In a *New York Times* polemic decrying CPMs, OBGYN Amy Tuteur described CPMs as "poorly trained midwives" and noted:

> They used to be called "lay midwives" or "direct entry midwives," in recognition of their lack of formal medical schooling. That didn't sound very impressive. In a brilliant marketing ploy, they created a credential—the C.P.M.—and awarded it to themselves. Many receive their education through correspondence courses and their training through apprenticeships with another C.P.M., observing several dozen births and presiding at fewer.[81]

Tuteur advocated abolishing the credential entirely, imploring states to "demand that all American midwives meet international standards; keep women at increased risk of complications from giving birth at home; insist on transfer to a hospital at the first hint of potential problems; and require that midwives have hospital privileges."[82] Yet responses to the controversial article revealed that some states—including Illinois—have labored to create standards that will incorporate CPMs into the existing medical regime and regulate home births to make them safer for those who elect to pursue them.[83]

In contrast to Tuteur's critique, other scholars argue the CPM's embrace of multiple forms of training and experience is a strength. Keisha La'Nesha Goode writes, "The CPM recognizes the diverse ways in which people enter into midwifery: apprenticeship, self-study, private midwifery schools, col-

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[80] Samuel Blackstone, *New Midwife Certification in S.D. Allows Home Births with Less Education and Clinical Training*, South Dakota News Watch (Nov. 26, 2019), https://www.sdnewswatch.org/stories/new-midwife-certification-in-s-d-allows-more-home-births-with-less-clinical-training [https://perma.cc/4YT9-5KDZ].

[81] Tuteur, *supra* note 76.

[82] *Id.*

[83] *See* Elisa Talentino, Opinion, *Letters: How Safe is Home Birth?*, N.Y. Times (May 7, 2016), https://www.nytimes.com/2016/05/08/opinion/sunday/how-safe-is-home-birth.html [https://perma.cc/2R83-44CB] (noting the obstetric community in Illinois has "worked closely with the C.P.M. community on new legislation that incorporates what we felt was essential to make home birth safer. . ."). For a critique of Tuteur's article, see Faith Gibson, *Amy Tuteur's Fact-Free Zone* (May 3, 2016), https://faithgibson.org/mcdg-amy-tuteur-question-why-people-think-american-home-birth-dangerous-may2-2016/ [https://perma.cc/L4S8-9SGZ]. For a critique of Tuteur's work that pre-dated her *New York Times* article, see Jennifer Block, *How to Scare Women,* Slate (Jul. 3, 2012), https://slate.com/human-interest/2012/07/daily-beast-and-home-birth-fear-trumps-data-in-a-new-story-on-having-babies-at-home.html [https://perma.cc/Q539-VD4H]. (Block writes: "Also known as "Dr. Amy," Tuteur let her medical license lapse in 2003 and created the blog Home Birth Debate in 2006, which she used to advocate for her position, which is basically: Home birth kills babies. 'Even the studies that claim to show that home birth is as safe as hospital birth actually show the opposite,' she'd frequently post in response to a challenge, smearing the researchers of those studies in dedicated blog posts and igniting flame wars in the comments section. On other sites, including Nature and RH Reality Check, her comments have been flagged and removed for being defamatory or basically spam. . . . Her prose tends to be inflammatory. 'It's hard to beat homebirth midwives when it comes to stupidity,' she recently blogged on her own site." *Id.*

lege- and university-based midwifery programs and nurse-midwifery."[84] Julie Morel echoes this sense of CPMs as rooted in experiential knowledge—precisely the kind of knowledge that feminists have long noted conventional institutions regulate, surveil, and even denigrate.[85] Morel writes that CPM's training allows them "to trust and create their own knowledge through experience and instinct rather than simply receive the information that trickles down to them from higher-status professional groups creating knowledge for ulterior motives."[86] Indeed, many CPMs and aspiring CPMs—including Morel—explicitly note their commitment to aiding birthing bodies outside of institutional medicine, with a particular commitment to aiding birthing Black bodies.[87] CPMs are the only kinds of midwives required to prepare for births in non-medicalized settings.[88] Because we inhabit a moment where Black birthing people in particular have been urged in mainstream media to consider non-medicalized birth settings, CPMs are essential actors in ensuring healthy Black birth outcomes.

Yet the history of certifying and licensing midwives has long been defined by an effort to bar Black midwives—historically termed "granny midwives"—from the profession. Such efforts have claimed to operate for the benefit of patient safety, but in reality, have been motivated by securing elite access to credentialization. For example, efforts in Alabama to curb competition between midwifery and obstetricians resulted in legislation ending lay midwifery and criminalizing non-hospital midwifery, greatly reducing the

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[84] Keisha La'Nesha Goode, Birthing, Blackness, and the Body: Black Midwives and Experiential Continuities of Institutional Racism (Oct. 2014) (PhD Dissertation, CUNY) (on file with the CUNY Graduate Center) at 65, https://academicworks.cuny.edu/gc_etds/423/ [https://perma.cc/CYW6-8PHH].

[85] Interview with Julie Morel, April 2020, Zoom.

[86] Julie Morel, Black Birthing Mothers: The Historical Context and Potential Benefits of Midwifery-Based Care, at 32 (2019) (B.A. thesis, Vassar College) (on file with Vassar College libraries), https://digitalwindow.vassar.edu/cgi/viewcontent.cgi?article=1921&context=senior_capstone [https://perma.cc/H2L3-8ZYC].

[87] *Why There's Only One Black Certified Professional Midwife in Philadelphia*, WHYY (Apr. 2, 2019), https://whyy.org/episodes/why-theres-only-one-black-certified-professional-midwife-in-philadelphia/ [https://perma.cc/UZV8-5MES]. Much of this conversation changes with COVID-19, which increasingly treated birth not as a time of unwellness requiring a hospital but as a time of health, unless a pregnancy is deemed "risky." *See* Wendy Kline & Hermine Hayes-Klein, *Covid-19 Exposes the Need for Midwives*, WASH. PO. (May 5, 2020), https://www.washingtonpost.com/outlook/2020/05/05/midwifes-tale/ [https://perma.cc/YPH3-MCQU]. Julie Morel notes that credentialization grants CNMs access to loan repayment plans through the National Health Service Corps Program—often $30,000–50,000—if they agree to serve underprivileged communities. Thus, she argues students are drawn to the CNM certification. She writes, "extending loan repayment programs to CPMs would undoubtedly diversify the demographics of midwives attending to home birth, birth center delivery, and postpartum care." She also notes that Medicaid reimbursement rules impact students' decisions to pursue the CPM or CNM, since 21 states reimburse CNMs and seven CPMs, and ten don't reimburse birthing centers or home births. Morel, *supra* note 86, at i, 41.

[88] *See* Taylor Allen, *Exploring Alternatives: Black Midwives Serving Black Mothers*, WOMANLY (Feb. 13, 2019), https://www.womanlymag.com/black-maternal-health/exploring-alternatives-black-midwives-serving-black-mothers [https://perma.cc/FL2N-L7RL].

previously high number of Black midwives working in the state.[89] Katherine Webb-Heh writes that this moment meant that "the Black, rural women who'd relied on midwives for generations were suddenly being shuffled into an institution they were once banned from entering. And the Black midwives who had built a profession for themselves were now without work, deemed dirty and illegitimate by the white leaders of the state."[90] The effects of this intensely racialized regulation continue to shape Alabama's birth landscape: its infant mortality rate is one of the highest in the country.[91] Alabama's complete lack of midwifery education programs and its requirement that CNMs have a "collaborative physician" overseeing their practice have made it difficult for midwives to find work in the state.[92]

While midwifery credentials were born, at least in part, out of a desire to secure medical authority from the experiential authority of Black midwives, Black mothers have increasingly sought Black midwives—especially during COVID-19—and found it challenging to find Black providers. News sources described that Black women were increasingly likely to turn to midwives during labor, a response both to fear about COVID-19 and to ongoing reports of anti-Black obstetric violence.[93] Jamarah Amani, a Florida midwife and co-founder of the National Black Midwives Alliance, noted "[e]very midwife I'm talking to has seen their practice double or sometimes triple in the wake of COVID."[94] Rachel Scheier reports that recent years have resulted in a "growing Black midwifery movement that harks back to a venerable, if long-forgotten, tradition in the United States."[95] So at once we inhabit a moment where Black mothers are increasingly hearing of the dangers of the hospital and the possible importance of home birthing, and yet law and medicine have collaborated to make that option out of reach—if not wholly impossible—for many Black birthing people. In noting this paradox, my impulse is not to advocate for home birthing as a panacea; instead, I seek to highlight how at once Black birthing people can be told that a particular birthing practice will guarantee them safety only to find that the option is unavailable or hard to attain.

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[89] *See* Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 76–77 (2004).

[90] Katherine Webb-Hehn, *Alabama May Have Solutions to the Nation's Black Maternal Health Crisis*, SCALAWAG (Sept. 24, 2018), https://scalawagmagazine.org/2018/09/alabama-birth-coaching/ [https://perma.cc/7H8S-YUKU].

[91] *See Infant Mortality Rates by State*, CDC (2020) https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm [https://perma.cc/2S54-3N55].

[92] *See* Nina Martin, *A Larger Role for Midwives Could Improve Deficient U.S. Care for Mothers and Babies*, PROPUBLICA (Feb. 22, 2018), https://www.propublica.org/article/midwives-study-maternal-neonatal-care [https://perma.cc/NJ2Q-7Q3S].

[93] *See* Rachel Scheier, *Black Women Turn to Midwives to Avoid COVID and 'Feel Cared For,'* MEDICAL XPRESS (Oct. 1, 2020), https://medicalxpress.com/news/2020-10-black-women-midwives-covid.html [https://perma.cc/MX5B-U33J].

[94] *Id.*

[95] *Id.*

The Lactation Industry

In 2016, the Georgia Assembly passed the Georgia Lactation Consultant Practice Act.[96] The effects of the law were that it:

> Prohibit[ed] providing lactation care and services for compensation without obtaining a license from the Secretary of State. Legislators at the time said the purpose was "to protect the health, safety and welfare of the public by providing for the licensure and regulation of the activities of persons engaged in lactation care and services." . . . [T]he law . . . essentially meant that anyone who wanted to assist with breastfeeding had to be licensed as an International Board Certified Lactation Consultant, or IBCLC. That meant completing eight college-level health and science classes, six health-related continuing education courses, 300 hours of supervised clinical experience and passing an exam.[97]

At the time the law was passed, Georgia had many more certified lactation counselors (CLCs) than IBCLCs,[98] but the law made it such that CLCs could only practice on a volunteer-basis unless they were working under the auspices of a federally funded office. The CLCs practicing at that time were also more racially diverse in makeup and populations served, creating concern that the passage of the bill would increase disparities in breastfeeding rates in communities of color.[99] The non-profit Reaching Our Sisters Everywhere (ROSE) challenged the Georgia Lactation Consultant Practice Act in

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[96] O.C.G.A. §43-22A-1 (2016), https://sos.ga.gov/PLB/acrobat/Forms/63%20Reference%20-%20Georgia%20Lactation%20Consultant%20Practice%20Act.pdf [https://perma.cc/7MLQ-CTRJ]. The act noted:

> The General Assembly acknowledges that the application of specific knowledge and skills relating to breastfeeding is important to the health of mothers and babies and acknowledges further that the rendering of sound lactation care and services in hospitals, physician practices, private homes, and other settings requires trained and competent professionals. It is declared, therefore, to be the purpose of this chapter to protect the health, safety, and welfare of the public by providing for the licensure and regulation of the activities of persons engaged in lactation care and services.

[97] Breaking News Staff, *Ga. Supreme Court Says Lactation Counselors' Lawsuit over Licensing Law Can Proceed*, Atlanta J. & Const. (May 18, 2020), https://www.ajc.com/news/breaking-news/supreme-court-says-lactation-counselors-lawsuit-over-licensing-law-can-proceed/RBNU5uLAcftg9XE19oezQJ/ [https://perma.cc/TR8T-ZRHU].

[98] *See id.* (noting that "[a]ccording to court documents, there are only 335 IBCLCs in Georgia, compared to 800 CLCs").

[99] *See* Sahira A. Long & Kimarie Bugg, *Can't We All Just Get Along?*, 31(1) J. of Human Lactation 29 (2015) ("At the time the Georgia bill was introduced, CLCs outnumbered IBCLCs and were more racially diverse in makeup and populations served. . . . Our concern was that passage of the bill would inherently decrease access to lactation care and potentially increase disparities in breastfeeding rates in communities of color that were served by non-IBCLC lactation specialists.").

a 2018 lawsuit.[100] The Georgia Supreme Court recently ruled in favor of the lactation consultants, sending the case back to the trial court to reconsider the state's motion to dismiss.[101] The Georgia Supreme Court noted in its decision, "We have long interpreted the Georgia Constitution as protecting a right to work in one's chosen profession free from unreasonable government interference."[102] Why might the state maintain an investment in rendering CLCs invisible in a moment when it purports to be invested in supporting breastfeeding, particularly Black breastfeeding, as a key technology supporting Black life? Why would the state pass such a law in a moment when the U.S. Surgeon General recommended that communities have between eight and nine board-certified lactation counselors for every 1,000 live births?[103] Georgia has fewer than three IBCLCs per 1,000 live births, according to the CDC.[104]

While much of the legal scholarship on breastfeeding has focused on workers' breastfeeding rights,[105] I turn my attention to how the same regime of stratification that marks midwives also marks the lactation industry, granting heightened legitimacy to IBCLCs based on their proximity to medicalized education while marking CLCs and peer lactation consultants as less legitimate. The International Board of Lactation Consultant Examiners (IBLCE), which certifies IBCLCs, was founded in 1985 "in response to the need for standards in the emerging profession of lactation consulting."[106] IBCLC's sit for a four-hour certification exam after completing one of three pathways: (1) practice as a health professional, (2) completion of a human lactation and breastfeeding academic program, or (3) a structured mentor-

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[100] Dave Williams, *Georgia Supreme Court Rules in Favor of Lactation Counselors*, The Augusta Chronicle (May 18, 2020), https://www.augustachronicle.com/news/20200518/georgia-supreme-court-rules-in-favor-of-lactation-counselors [https://perma.cc/YN7W-L7BT].

[101] *Id.*

[102] *Id.*

[103] *See* Samantha Max, *Fewer Babies Breastfeed in Georgia than in Almost Any State. Soon, It Could Get Worse*, The Telegraph (Sept. 21, 2018), https://www.macon.com/news/local/article218589310.html [https://perma.cc/4HMT-JBC5].

[104] *Id.*

[105] *See, e.g.*, Shana M. Christrup, *Breastfeeding in the American Workplace*, 9 Am. U. J. Gender Soc. Pol'y & L. 471 (2001); Corey Silberstein Shadimah, *Why Breastfeeding is (Also) a Legal Issue*, 10 Hastings Women's L.J. 409 (1999); Marcy Karin & Robin Runge, *Breastfeeding and a New Type of Employment Law*, 63 Cath. U. L. Rev. 329 (2013-2014); Kristin A. Zach, *Federal Protections for Breastfeeding Mothers in the Workplace*, 60 Fed. Law 16 (2013). Crucial exceptions are Andrea Freeman, *Unmothering Black Women: Formula Feeding as an Incident of Slavery*, 69 Hastings L.J. 1545 (2018); Andrea Freeman, *First Food Justice: Racial Disparities in Infant Feeding as Food Oppression*, 83 FORDHAM L. REV. 3053 (2014-2015); Saru Matambanadzo's work on "the fourth trimester" profoundly argues for legal attention to the "fourth trimester," "a conceptual framework drawn from maternal nursing and midwifery that reconstructs pregnancy to include a three to six month period of rest, recovery, and transition after the birth of a child." 48 U. Mich. J. L. Reform 117, 120 (2014).

[106] ILCE: *History*, International Board of Lactation Consultant Examiners, https://iblce.org/about-iblce/history/ [https://perma.cc/D9JP-VASB].

ship with an IBCLC.[107] The Certified Lactation Counselor (CLC) is a less medicalized certification, as its practitioners "work within a counseling model."[108] CLCs must pass a two-hour exam after qualifying through one of three paths: (1) completing a comprehensive Breastfeeding Counseling Training Course; (2) providing proof that they are a licensed health professional or hold a bachelor's degree, and have completed a minimum of 45 hours of education related to a Breastfeeding Counseling Training Course; or (3) graduating from an approved post-secondary lactation consultant program.[109] Peer Counselors work in a variety of venues—including for WIC—to support breastfeeding people in their community.

Some scholars note that IBCLCs are "more likely to come from a clinical or academic background (physicians and registered nurses, for example), and CLCs may tend to be more holistic-minded (registered midwives, doulas, etc.)."[110] This has produced a set of conditions where, as Allers notes:

> As I travel the country, I'm always asking everyone and anyone if they knew of any African American IBCLC's. . . . In some cities, there are stories and urban legends of black IBCLC's but few could actually name any names. At one point, I wondered if I was searching for black IBCLCs or Big Foot.[111]

While IBCLCs may be regarded by lawmakers as more legitimate due to their medicalized backgrounds, some argue that peer counselors are actually more effective in ameliorating the racial breastfeeding gap, at least in part because peer counselors often emerge from the communities they serve. One professional from a national non-profit running peer lactation counselor training noted:

> Peer counseling is nonclinical, and doulas used to be like that and there was no money in it. There's still no money in breastfeeding peer counseling and there's no competition, now there's competition for licensure to the exclusion of other lactation support. But

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[107] *Step 1: Prepare for IBCLC Certification,* INTERNATIONAL BOARD OF LACTATION CONSULTANT EXAMINERS, https://iblce.org/step-1-prepare-for-ibclc-certification/ [https://perma.cc/9PWV-F4XP].

[108] *The CLC-Certified Lactation Counselor,* THE ACADEMY OF LACTATION POLICY AND PRACTICE (Jun. 4, 2019), https://alpp.org/certifications/certifications-clc [https://perma.cc/5KLX-KP8N].

[109] *Id.*

[110] *What's a CLC vs. an IBCLC? How to Choose a Lactation Consultant*, MAMAMEND (Feb. 25, 2020), https://www.mamamend.com/postpartum-health/CLC-vs-IBCLC-choose-a-lactation-consultant#:~:text=A%20Certified%20Lactation%20Counselor%20(CLC,and%20passed%20a%20certification%20exam [https://perma.cc/67YL-LAEA].

[111] Kimberly Seals Allers, *Saving Ourselves: Increasing Representation and Changing the Black Breastfeeding Narrative*, MOMSRISING (Feb. 26, 2013), https://www.momsrising.org/blog/saving-ourselves-increasing-representation-and-changing-the-black-breastfeeding-narrative [https://perma.cc/Y2TJ-MWXE].

> we found peer counselors were more effective than the licensed professionals. We got better outcomes with less credentials, so now what we're doing is credentializing and licensing the profession to the exclusion of what works.[112]

Her comments underscore that while the field of lactation has become increasingly (and only recently) credentialized, training community members to talk to each other about breastfeeding is the most effective way to change public health outcomes and to encourage Black breastfeeding. Indeed, her program—along with efforts like Kimberly Seals Allers' National Black Breastfeeding week and Vanessa Simmons' digital effort #normalizebreastfeeding—aids to make visible community members who breastfeed in the service of normalizing and even celebrating Black breastfeeding.[113]

In the case of both midwifery and lactation, stratification and credentialization operate in the name of patient health and safety but work to pernicious ends reproducing racial hierarchies and disparities, leaving Black providers either fighting for access to institutional recognition or performing their anti-medical work from positions of precarity. While my claim is not that Black providers are the only ones who can adequately serve Black patients, there has been increased visibility to the fact that, in the case of maternal and infant health outcomes, Black providers can quite literally save lives. Rachel Hardeman's research examining 1.8 million births in Florida between 1992 and 2015 found that Black newborns cared for by Black providers were significantly less likely to die.[114] In the context of breastfeeding, research has emphasized that relatively low Black breastfeeding rates might be explained by a lack of support for Black breastfeeders. Angela Johnson, Rosalind Kirk, Katherine Lisa Rosenblum, and Maria Muzik note:

> Despite great need, African American mothers are less likely than other groups of women to receive support or treatment for their social, physical, or emotional needs. Black mothers in the United States are also disproportionately more likely to experience the workplace as unsupportive of breastfeeding. On average, they return to work at 8 weeks postpartum, which is earlier than women from other racial and ethnic groups, and once they return to work, they encounter less flexible work conditions. Finally, several modifiable predictors of low rates of breastfeeding, such as lack of personal support, inadequate access to professional breastfeeding

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[112] Personal interview, Feb. 2017.

[113] I discuss #normalize and Black Breastfeeding week in my forthcoming book. *See* Nash, *supra* note 21.

[114] *See* Short Wave, *A Key to Black Infant Survival? Black Doctors*, NPR (Sept. 18, 2020) https://www.npr.org/transcripts/913718630 [https://perma.cc/D2XG-Z654].

> resources, racially biased health care, and low breastfeeding self-efficacy, contribute to the range of breastfeeding challenges.[115]

Their research emphasizes the importance of community-rooted "support" for Black breastfeeding, support which can transform community attitudes and perceptions of breastfeeding entirely.[116] The emphasis on community-rooted re-signification of breastfeeding suggests precisely the importance of peer lactation efforts—rather than more institutionalized medical efforts—for altering Black breastfeeding outcomes.

My attention to these two professions—both of which are part of what I have elsewhere termed the "feminist birthing industry" and crucial parts of perinatal caregiving—reveal the importance of a reproductive justice lens that thinks about violence expansively and well beyond the site of the hospital.[117] We need a lens that conceives of harm broadly, attending to how racial maternal health disparities are made both in the delivery room and in seemingly benign acts of credentializing those who labor in the birth industry. My interest in the politics of credentials—particularly in the feminist birthing industry—is to trace how the rush toward professionalization in fields like lactation support and midwifery can *both* ensure safer outcomes and shore up hierarchies. It can work to protect birthing people and to limit their access to the highest-paid credentials.

III. The Geographical Perspective

While reproductive justice advocates have developed an ambivalent stance on the hospital, both bemoaning its absence—particularly from urban centers—and describing the host of ways it inflicts violence on Black maternal flesh, I suggest that we think about birth justice differently. Indeed, the geographical perspective I advance suggests that we attend to the topographies and ecologies that are produced that relegate Black mothers to spaces of non-care of a variety of kinds. In thinking about birth geographies as producing forms of obstetric violence, rather than simply the hospital as the site of obstetric harm, I argue that we can link Black maternal health and survival to spaces beyond the delivery room, to include the kinds of care required to support Black life throughout the perinatal period, care that includes lactation support (if breastfeeding is desired), doulas, midwives, access to transportation for perinatal visits, and postpartum leave from work. In other words, the focus on the hospital presumes that the hospital is the only site of death for Black mothers and children, rather than one dense node

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[115] Angela Johnson et al., *Enhancing Breastfeeding Rates Among African American Women: A Systematic Review of Current Psychosocial Interventions* 10(1) Breastfeeding Medicine 45, 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4307211/#B58 [https://perma.cc/8EWB-CFHP].

[116] *See id.*

[117] *See* Nash, *supra* note 21.

among many where violence is inflicted. A geographical perspective thinks about the constellation of forces that make some areas dense sites of perinatal care, and others barren; it also thinks about how even dense sites of care—say, for example, the metropole—can still provide non-care to Black mothers and children because of the location of hospitals, the kinds of perinatal care that is available, and the commitment (or non-commitment) of providers to safeguarding Black life. Indeed, a geographical perspective emphasizes the importance of Black feminist cartographical efforts that can map access to hospitals alongside access to peer lactation consultants, state laws governing midwifery, access to public transportation to travel to prenatal visits, etc.

I argue that we will be equipped to think about the presence and absence of care with new rigor, with a particular attention to how institutionalized medicine leaves Black women and children subjected to myriad forms of non-care as it purportedly works to shore up safety and standardization, producing the crisis we currently see. In other words, a geographical perspective compels us to analyze how shorthand like "rural" and "urban" actually fail to capture the variation within those spaces, variations that can leave a space like Chicago with maternal health care deserts that disproportionately affect Black mothers on the South Side, *and* with a research hospital in the city-center (Prentice Women's Hospital at Northwestern) that is the "highest volume maternity hospital in Illinois."[118] In particular, I argue that we turn our attention to how law and medicine collaborate through ideas of certification and standardization to mark and make space. My understanding of birth—and birth justice—as a geographical matter and thus necessarily as a racialized question is indebted to Black feminist theorist Katherine McKittrick, whose work considers the "interplay between domination and black women's geographies."[119] McKittrick writes, "I am suggesting that the relationship between Black women and geography opens up a conceptual arena through which more humanly workable geographies can be and are imagined."[120] When she reminds readers that "Black matters are spatial matters,"[121] this does not mean that they are not legal or medical matters, but that space organizes access to care (or non-care), to public transportation to move to prenatal appointments, to the nearest hospital, to providers, to peer support for breastfeeding parents or new parents. Her work requires that we ask about the landscapes that disparity creates—landscapes which are inhabited and fought against in quotidian and spectacular ways.

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[118] Kara Spak, *Northwestern Memorial Hospital Recognized by Consumer Reports for Low C-Section Rates*, Nw. Med. (Apr. 22, 2016), https://www.nm.org/about-us/northwestern-medicine-newsroom/nm-news-blog/nm-hospital-recognized-by-consumer-reports-for-low-c-section-rates [https://perma.cc/MTV2-ZR5C].

[119] Katherine McKittrick, Demonic Grounds: Black Women and the Cartographies of Struggle xi (2006).

[120] *Id.* at xii.

[121] *Id.*

A geographical perspective also helps us think about how seemingly disconnected people—Black mothers in Chicago's south side and Black mothers in rural North Carolina—share the experience of non-access to medical care resulting from the shuttering of maternity wards and the mandate to travel lengthy distances to secure prenatal care and delivery. This same perspective allows us to explore how the state might celebrate Black breastfeeding in the same moment that Baby-Friendly Hospitals continue to "bypass" Black communities.[122] Or it allows us to study how local hospitals close their maternity wards while research hospitals in large urban centers report that their maternity wards are thriving and growing. This same perspective recognizes that non-care and racial disparities are geographically allocated, felt and inhabited across spaces in distinct ways, but always shaped by space. The geographical perspective asks: How might we think both about the micro-ecologies specific to place and about what unites Black women, thinking about non-care as both a general fixture in Black birthing mothers' lives and as something that is lived, felt, and practiced in particular ways? How might we think about non-care as an ecological question that produces wholesale topographies? Finally, the geographical perspective spotlights how we live in a country where birth outcomes vary dramatically by state, by county, and even by hospital (indeed, pregnant people are often advised to check hospital C-section rates before deciding where to deliver). These are fundamentally geographical questions—*where* one births can fundamentally shape the quality of care (or absence of care) one receives. It can shape whether one lives or dies.

Ultimately, my hope is that the geographical perspective—which McKittrick reminds us is one that enables us to cultivate more "humane" visions of the shared world—is a tool for reproductive justice advocates to continue their work laboring for birth justice, for the visibility of the violence Black mothers experience inside and outside of the hospital as they struggle for "More Life," both the life of their unborn or newly born children, the lives of their children as they grow, and their own lives as they experience perinatal citizenship.

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[122] *See* Rita Henley Jensen, *'Baby-Friendly' Hospitals Bypass Black Communities*, WOMEN'S ENEWS (Aug. 9, 2013), https://womensenews.org/2013/08/baby-friendly-hospitals-bypass-black-communities/#.UiCt8n-29zp [https://perma.cc/8Q5L-MFRL].